ALABAMA MEDICAID AGENCY

STATEMENT OF CLAIMANT OR OTHER PERSON

Name of Claimant	Social Security Number
(1)	**(2)**
Name of Person Making Statement (if other than above claimant)	Relationship to Claimant
(3)	**(4)**

Understanding that this statement is for a right to payment of Medicaid benefits by Alabama Medicaid Agency, I hereby certify that:

(5)

SIGN ON BACK

I understand that anyone who knowingly makes a false statement or misrepresents material facts in an application to determine eligibility for Medicaid may be committing a crime punishable under Federal or State law, or both. I affirm that all information I have given in this document, or in support of it, is true.

==========

In signing this statement, I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT

Signature (First name, middle initial, last name) (Write in ink)

S I G N **(7)**
Date (Month, day, year)

H E R E **(6)** **(8)**
Telephone Number

==========

Mailing Address (Number and Street, Apt. No., P.O. Box, Rural Route)

(9)
City and State Zip Code

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. Signature of Witness 2. Signature of Witness

(10) **(11)**
Address (Number and Street, City, State, and Zip Code) | Address (Number and Street, City, State, and Zip Code)

(12) **(13)**